child to hospital if it seems possible that it has been deliberately injured, whether by parents or baby-minder or older sibling. The child is then in a "place of safety" and can be kept there, as the B.P.A. memorandum makes clear. But once it is there, the best interests of the baby and the rehabilitation of the parents are not contradictory aims: they are joint ones, and the apparatus for dealing with both is available.—I am, etc.,

Whittington Hospital,
London N.19.

SIMON YUDKIN.

Trusses for Femoral Hernia

SIR,—The facts of anatomy will not support even the very limited approval of femoral trusses expressed by Mr. R. J. McNeill Love (12 March, p. 673).

The sac of a femoral hernia descends at first vertically and lies between rigid structures—the pubic bone and the inguinal ligament. Here it is not susceptible to influence by any form of external truss. The sac is always elongated and relatively narrow in its first part. When it turns forward into the femoral triangle after escaping from under the inguinal ligament it may have a substantial globular fundus. More often it does not but remains a relatively small sac surmounted by a thick cap derived from the pro-peritoneal fat and fascia. Sometimes the fundus of the sac remains deep in the femoral canal, and the swelling, which can be seen or palpated, consists entirely of fatty cap.

When the hip-joint is fixed a truss can be made to exert continuous pressure on the femoral triangle and on any swelling in it, but from the foregoing it follows that no truss can prevent the first part of the femoral sac from being filled from above, and this precisely constitutes the danger of femoral hernia. A truss in this condition is as efficient as an inguinal truss, which presses on the external ring when the hernia has escaped from the internal ring—that is, it is totally inefficient.—I am, etc.,

Birmingham 15.

F. WELSH.

Umbilical Hernia

SIR,—At the first Commonwealth Medical Conference held in Edinburgh in October 1965 it was agreed that young doctors should be encouraged to undertake a tour of service in the developing Commonwealth countries. Apart from various emergencies such as injuries, together with other diverse sudden misfortunes, some more interesting cases face the young doctor, such as the one reported below—the most interesting of a number of

cases during my first year at this district hospital. Such cases are not uncommon, but I thought this one to be worth recording for the interest of prospective young doctors in the developing countries.

A 27-year-old Tumbuka female was admitted to this hospital with complaints of "swelling" of the abdomen since the birth of her third child five years before. She had borne two more since then. Her general health was good. There was a pyriform swelling 10 in. by 5 in. (25 cm. by 12 cm.) in the umbilical region (Fig.). The skin over it was stretched, obliterating the position and evidence of the umbilicus. The veins over the swelling were prominent (O), and there were trophic ulcers (X) on the most dependent part of the swelling. The swelling was soft and tympanitic. It reduced completely in the recumbent position, leaving a puckered ulcerated flap of skin.

The patient refused to travel the 400 miles to Blantyre for the attention of the surgical specialist.

A repair was performed as follows: The mass was reduced and the redundant skin clamped by means of occlusive intestinal clamps. An incision was made parallel to the rectus muscle on either side, and the redundant ulcerated sac excised, leaving an incision 6 in. (15 cm.) long with a gap similar to one in an ordinary midline laparotomy incision. The redundant sac had a capacity of 250 ml.

The recti muscles were defined; the right tucked under the left and their edges secured.¹ The skin was closed with interrupted sutures.

The patient recovered uneventfully, and was discharged 10 days later. She reported on 15 January 1966 for a check-up.

I wish to thank the Secretary for Health, Malawi Ministry of Health, for permission to publish this case, and the hospital staff for their assistance.

—I am, etc.,

District Hospital,
Mzimba, Malawi.

Y. H. MISOMALI.

REFERENCE

- ¹ *Rose and Carless Manual of Surgery*, 1960, 19th ed. London.

Serum Leucine Amino Peptidase Activity in Carcinoma of the Stomach with Metastases

SIR,—A modification of the method of Goldbarg and Ruttenburg¹ for the determination of leucine amino peptidase is described in the *Sigma Technical Bulletin No. 250*. Reference was found to the levels of serum leucine amino peptidase in various diseases, the highest values being found in carcinoma of the head of the pancreas, 450–1,270 G.R. units.

A man aged 65 years was admitted to this hospital with a history of confusion, vomiting, and back pain. A provisional diagnosis of carcinoma of the pancreas was apparently supported by a serum leucine amino peptidase of 1,000 G.R. units and an alkaline phosphatase of 44 K.A. units. The presence of metastases was suggested by the serum phosphohexose isomerase of 290 i.u./l. rising to 470 i.u./l.² The barium meal demonstrated an ulcer high up on the greater curve of the stomach, which at necropsy was shown to be malignant, with secondary deposits in the liver. The pancreas was normal.

It is interesting that in this case a greatly elevated serum leucine amino peptidase was found in the presence of a carcinoma not arising in the pancreas. The diagnostic

value of this enzyme may perhaps be limited.—We are, etc.,

W. H. S. GEORGE.
K. J. GURLING.
I. MACKENZIE.

Derbyshire Royal Infirmary,
Derby.

REFERENCES

- ¹ Goldbarg, J. A., and Ruttenburg, A. M., *Cancer*, 1958, 11, 283.
- ² Bruns, F. H., and Jacob, W., *Klin. Wschr.*, 1954, 32, 1041.

Home Treatment of Pulmonary Tuberculosis

SIR,—Dr. K. M. Citron's (12 March, p. 657) list of tuberculous patients unsuitable for home treatment can be reduced by at least one—namely, "Infectious patients with susceptible family contacts." Dormer and his colleagues¹ have shown that isoniazid is an excellent prophylactic for infants nursed by infectious mothers. It must be no less protective for other family contacts. My practice is to give isoniazid to all child contacts of infectious cases treated while remaining at work. Any children tuberculin negative six weeks after the start of prophylaxis are vaccinated with isoniazid-resistant B.C.G. under cover of isoniazid until conversion occurs.

Dr. Citron, in clearly setting out the undoubted merits of treatment at home and at work, regrettably repeats some traditional dogma concerning spread of infection. Infection is spread by airborne droplets, and there is no proof that bed linen, crockery, or dried sputum is ever involved. Disinfectants are as unimportant as rest, nutritious food, and fresh air.

A separate room is unnecessary. An adequate supply of handkerchiefs to cover the mouth during coughing should suffice.—I am, etc.,

Mullingar,
Ireland.

MICHAEL P. FLYNN.

REFERENCE

- ¹ Dormer, B. A., Harrison, I., Swart, J. A., and Vidor, S. R., *Lancet*, 1959, 2, 902.

Treatment of Sinusitis

SIR,—In his article on diagnosis and treatment of sinusitis (2 April, p. 834) Mr. J. D. K. Dawes does not mention nasal decongestants or steam inhalation.

Does this mean that he feels there is no value in either of these procedures?—I am, etc.,

Reepham, Norfolk.

A. S. GARRETT.

Post-vagotomy Neuroma

SIR,—In reference to your leading article on this subject (19 March, p. 694) a former senior house-officer of mine, Mr. E. J. Guiney, and myself reported a case of this condition in March 1960.¹

Our patient's major complaint was of dysphagia with a narrowed area demonstrable in the lower thoracic oesophagus; biopsy showed only inflammatory change. At thoracotomy the narrowing was found to be due to a small "stump neuroma" densely